



Commonwealth of Massachusetts, Department of Public Health, Division of Food and Drugs
305 South Street, Jamaica Plain, MA 02130
Telephone 617 983-6700 Fax 617 524-8062

Application for Massachusetts Controlled Substances Registration to Manufacture or Distribute
In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C

Please be sure to:

- Complete the application form
- Enclose check or money order for \$300 made payable to "Commonwealth of Massachusetts"
- No fee is charged if submitting this form only for *Amended Information*
- Sign and date the form at the bottom
- Mail to the address above

Incomplete applications will be returned and will cause a delay in receiving your MCSR. Do not send originals of any supporting documents. They will not be returned. Instead send photocopies.

For further information visit our Web site at <http://www.mass.gov/dph/dcp>

Application Type: (Please select one) ☐ New ☐ Renewal ☐ Amended Information

Registration Requested: ☐ Manufacture ☐ Distribute

In the boxes below enter the requested information.

1) Applicant: (Company Name)

2) Applicant Business Address: (Applications that include a P.O. Box number without a street address cannot be processed.)

3) Applicant Mailing Address: (If different)

4) Business Telephone No.:

()
area code

5) Federal Tax ID No.: (Required by M.G.L. c. 30A, s. 13A)

6) DEA Controlled Substance Registration No.: (If possessed)

7) **Distributors** check drug Schedules requested:

Select all that apply: ☐ II ☐ III ☐ IV ☐ V ☐ VI

Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.

8) **Manufacturers** check drug Schedules requested for each applicable category:

	II	III	IV	V	VI
Bulk Manufacturer, Synthesizer, Extractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dosage Form Manufacturer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repacker - Relabeler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9) Has the applicant ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ☐ Yes * ☐ No

10) Has any professional license or registration held by the applicant under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ☐ Yes * ☐ No

* If you answered "Yes" to Question No. 9 or No. 10, a letter must be attached setting forth circumstances of such action(s).

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health. I also certify, in accordance with M.G.L. c. 62C, s. 49A, that the applicant has to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.
Signed under the pains and penalties of perjury.

Signature of authorized individual _____
Responsible Person

Date _____

Print Name: _____

Title: _____

For Office Use Only	
Application approved by:	Comments:
Date:	